

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 3 — 0 1 0

2. STATE:

South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 2003

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY \_\_\_\_\_ \$ -0-

b. FFY \_\_\_\_\_ \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 3 to Attachment 3.1-A, Enclosure 3,  
Enclosure 4, Enclosure 5, Enclosure 6, Enclosure 7  
Page 1 thru Page 6 and Attachment 4.19-B, Page 6e  
and page 6f9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, Page 6e

10. SUBJECT OF AMENDMENT:

To replace the Program of All-Inclusive Care for the Elderly (PACE) from a waiver service  
to a State Plan service.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Robert M. Gurr

14. TITLE:

Director

15. DATE SUBMITTED:

July 28, 2003

16. RETURN TO:

South Carolina Department of Health and  
Human Services  
Post Office Box 8206  
Columbia, South Carolina 29202-8206**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

August 1, 2003

18. DATE APPROVED:

September 18, 2003

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2003

21. TYPED NAME:

Rhonda R. Cottrell

20. SIGNATURE OF REGIONAL OFFICIAL:

Hugh L. Webster  
Associate Regional Administrator  
Division of Medicaid & Children's Health

23. REMARKS:

**Supplement 3 to Attachment 3.1-A  
Enclosure 3**

State of South Carolina

**PACE State Plan Amendment Pre-Print**

Citation        3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy  
(Continued)

1905(a)(26) and 1934

  X   Program of All-Inclusive Care for the Elderly (PACE) services, as described and  
limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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TN No. MA 03-010

Supersedes

Approval Date 09/15/03

Effective Date 07/01/03

TN No. ~~N/A~~ NEW

**Supplement 3 to Attachment 3.1-A**  
**Enclosure 4**

**State of South Carolina**  
**PACE State Plan Amendment Pre-Print**

Citation        3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(26) and 1934

N/A Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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**Supplement 3 to Attachment 3.1-A  
Enclosure 5**

State of South Carolina

**PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

  X   Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

       No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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TN No. MA 03-010

Supersedes

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Supplement 3 to Attachment 3.1-A  
Enclosure 6

State of South Carolina

**PACE State Plan Amendment Pre-Print**

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

N/A Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

       No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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State of South Carolina  
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.  
N/A

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B.        The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

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**Regular Post Eligibility**

1. \_\_\_\_\_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. \_\_\_\_\_ The following standard included under the State plan (check one):

(a) \_\_\_\_\_ SSI

(b) \_\_\_\_\_ Medically Needy

(c) \_\_\_\_\_ The special income level for the institutionalized

(d) \_\_\_\_\_ Percent of the Federal Poverty Level: \_\_\_\_\_%

(e) \_\_\_\_\_ Other (specify): \_\_\_\_\_

2. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. \_\_\_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. \_\_\_\_\_ SSI Standard

2. \_\_\_\_\_ Optional State Supplement Standard

3. \_\_\_\_\_ Medically Needy Income Standard

4. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

5. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of \_\_\_\_\_ standard.

6. \_\_\_\_\_ The amount is determined using the following formula:

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7.\_\_\_\_ Not applicable (N/A)

(C.) Family (check one):

1.\_\_\_\_ AFDC need standard

2.\_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

4.\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of \_\_\_\_\_ standard.

5.\_\_\_\_ The amount is determined using the following formula:

\_\_\_\_\_

6.\_\_\_\_ Other

7.\_\_\_\_ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

**Regular Post Eligibility**

2. \_\_\_\_\_ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.\_\_\_\_ The following standard included under the State plan (check one):

(a) \_\_\_\_\_ SSI

(b) \_\_\_\_\_ Medically Needy

(c) \_\_\_\_\_ The special income level for the institutionalized



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- (d) \_\_\_\_\_ Percent of the Federal Poverty Level: \_\_\_\_\_ %  
(e) \_\_\_\_\_ Other (specify): \_\_\_\_\_  
2. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_  
    Note: If this amount changes, this item will be revised.  
3. \_\_\_\_\_ The following formula is used to determine the needs allowance:  
\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1. \_\_\_\_\_ The following standard under 42 CFR 435.121:  
\_\_\_\_\_  
2. \_\_\_\_\_ The Medically needy income standard  
\_\_\_\_\_  
3. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_  
    Note: If this amount changes, this item will be revised.  
4. \_\_\_\_\_ The following percentage of the following standard that is not  
    greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_  
    standard.  
5. \_\_\_\_\_ The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_  
6. \_\_\_\_\_ Not applicable (N/A)

(C.) Family (check one):

1. \_\_\_\_\_ AFDC need standard  
2. \_\_\_\_\_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_  
    Note: If this amount changes, this item will be revised.  
4. \_\_\_\_\_ The following percentage of the following standard that is not  
greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.

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5. \_\_\_\_\_ The amount is determined using the following formula:

\_\_\_\_\_

6. \_\_\_\_\_ Other

7. \_\_\_\_\_ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

**Spousal Post Eligibility**

3.  X  State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).  X  The following standard included under the State plan (check one):

1. \_\_\_\_\_ SSI

2. \_\_\_\_\_ Medically Needy

3.  X  The special income level for the institutionalized

4. \_\_\_\_\_ Percent of the Federal Poverty Level: \_\_\_\_\_ %

5. \_\_\_\_\_ Other (specify): \_\_\_\_\_

(B). \_\_\_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

(C). \_\_\_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_

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If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

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**II. Rates and Payments**

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.   X   Rates are set at a percent of fee-for-service costs
2.        Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.        Adjusted Community Rate (please describe)
4.        Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

**III. Enrollment and Disenrollment**

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment to private providers will not exceed the established statewide average cost for the service.

20.A

- & B Extended pregnancy related services are reimbursed individually at an established fee-for-service rate. All service rates are based on a statewide average cost for the service. Services rendered by public agencies will not exceed cost as required in 42 CFR 447.321 or 42 CFR 447.325.

24. Transportation: (Effective 3-10-87)

Ambulance: Payment for ambulance services will be the lesser of actual charges submitted by the carrier or the ceiling of the fees established by DHHS. The fee schedule will be applied uniformly without consideration of locality. In the aggregate, fees do not exceed Medicare (Title XVIII) reimbursement for the same service.

Other type of transportation: Reimbursement for other types of transportation not available free of charge is made on the following basis.

- Transportation provided by a common carrier at actual cost.
- Negotiated agreement on a cost per mile basis with organizations providing such services.
- Transportation by volunteers at a traveled fixed rate per mile.
- Transportation by taxi with a negotiated agreement on a fixed rate per mile.

24.g Birth Center: Payment will be made at an all inclusive facility rate according to an established fee schedule.

Program of all-Inclusive Care for the Elderly (PACE):

A. PACE Upper Limit Calculation:

1. Paid claims data from the SC Medicaid Management Information System (MMIS) is pulled for all Medicaid covered services which will be covered by the PACE program using the following criteria:
  - All covered Medicaid service costs (including Buy-in premiums) incurred by eligibles residing in nursing facilities located in Richland and Lexington counties are accumulated. State owned/operated nursing facilities and intermediate care facilities for the mentally retarded (i.e., ICF/MRs) are excluded from this analysis. Richland and Lexington counties represent the PACE site service area.

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SUPERSEDES: MA 99-002

- All covered Medicaid service costs (including Buy-in premiums) incurred by eligibles participating in the Community Long Term Care (CLTC) Program that reside in Richland and Lexington counties are accumulated. Additionally, case management costs originating from the CLTC area office which are reimbursed outside of South Carolina's MMIS are also included as a service cost. Richland and Lexington counties represent the PACE site service area.
  - The dates of service used in this analysis will cover the period December 1, 2001 through September 30, 2002 due to the state plan approval process employed by CMS.
  - Eligibility categories used in this analysis include both Medicaid and dual eligible recipients.
2. In addition to the determination of service cost from the paid claims data, member months will also be determined from the claims data. Member months for nursing facility eligibles are defined as whole or partial member months depending upon the admission and/or discharge date of the nursing facility resident. For eligibles participating in the CLTC program, member months are defined as whole or partial member months depending upon the entry and/or departure from the CLTC program.
  3. Medicaid service costs incurred by eligibles residing in nursing facilities and participating in the CLTC program will be adjusted by service specific inflation trends resulting from the implementation of Medicaid policy changes that were implemented during or after the claim reporting period but prior to the effective date of the rate period. Additionally, the South Carolina Department of Health and Human Services (SCDHHS) reserves the right to adjust the initial PACE Medicaid rate in the event of Medicaid policy changes during the course of the PACE rate period, subject to prior approval by the CMS regional office.
  4. Medicaid service cost expenditures as determined in (3) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Additionally, member months as determined in (2) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Total Medicaid service costs for each group (i.e., nursing home residents and CLTC participants) will be divided by total member months for each group to determine an average nursing home member month cost and an average CLTC member month cost.
  5. In order to calculate the upper payment limit for PACE participants, an adjustment for patient acuity must be made. Therefore, the average nursing home member month cost and the average CLTC member month cost as determined in (4) above will be weighted to determine the upper payment limit for PACE participants.

B. PACE Medicaid Rate Calculation:

The Medicaid rate for PACE participants will represent 99% of the weighted UPL as determined in (5) above.

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